THE Indian Health Program

U.S. PUBLIC HEALTH SERVICE






U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

THE Indian Health Program

OF THE U.S. PUBLIC HEALTH SERVICE

U.S. Department of Health, Education, and Welfare
Public Health Service
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Indian Health Service

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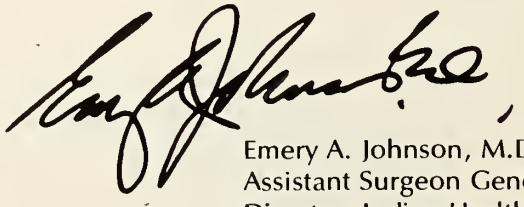
FOREWORD

From primitive beginnings in frontier Army posts more than a century ago, the Indian Health Program has evolved into a Federal - Tribal partnership with a common aim of raising the health status of the American Indian and Alaska Native people to the highest possible level. Much of this evolution—and progress—has taken place since 1955, when the Indian Health Program became the responsibility of the U.S. Public Health Service.

This Program is now on the threshold of an exciting future, one which holds the potential for finally closing the gap in health status between the American Indian and Alaska Native people and the rest of the Nation, and in the process, strengthen self-determination.

Key to understanding this future and the challenges facing it is understanding the Indian Health Program: its background, mission, organization, and activities — this is the purpose of this publication.



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Assistant Surgeon General, USPHS
Director, Indian Health Service

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ALASKA NATIVE HOSPITAL
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ALASKA


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American Indians and Alaska Natives, like other citizens, benefit from public health programs intended to improve health care for all Americans. Federally recognized Indians and Alaska Natives are eligible, in addition, for health services provided by the Indian Health Service (IHS), an arm of the U.S. Public Health Service's Health Services Administration. The Federal Government's responsibility for these nearly 700,000 Indians and Alaska Natives has a long history, originating from treaties of the past century, and further established through laws enacted by Congress.

Members of the more than 250 federally recognized Indian tribes live, for the most part, on Federal Indian reservations and in small rural communities. The majority of the 25 States in which Federal Indian reservations are located are in the western half of the nation. The Alaska Natives, a term embracing people of the Athabaskan, Tsimpsian, Tlingit and Haida Indian tribes and the Eskimo and Aleut peoples, live throughout Alaska, generally in remote, isolated villages.

The Indian and Alaska Native people have, in general, maintained much of their traditional culture. Some, especially the older people, speak little or no English. They are also among the most impoverished of any U.S. people, and are often deprived of such life - serving necessities as good nutrition and a sanitary environment. Many of the reservations and communities are located in isolated, rugged areas where climatic conditions can be very harsh. These conditions, coupled with a lack of roads, can make transportation difficult. In Alaska, for example, where roads in many areas where Natives live are non-existent, ill or injured persons have to be airlifted to health facilities.

Under such conditions, it is not surprising that a number of health-related problems exist in high proportions among Indians and Alaska Natives. Some of the most serious of these are accidents, alcoholism, mental health problems, otitis media (middle ear disease), mild and severe nutritional deficiencies, and poor dental health. Other major health concerns are maternal and child health needs, unhealthy enviromental conditions, and problems associated with aging.

Substantial progress has been made, however, in combating health problems, especially acute, infectious diseases. In 1955, for example, tuberculosis struck about eight out of every 1,000 Indians. By 1976, the number was down to less than one for every 1,000, representing a drop of 73 percent in the attack rate. Reductions have also been made in morbidity and mortality rates for other diseases. The mortality rate among infants by 1976 was down 69 percent since 1955, and influenza and pneumonia had been reduced by 59 percent. Another killer, gastroenteric diseases, has declined by 86 percent since 1955.

But much remains to be done before the Indian and Alaska Native people attain health parity with other Americans. In recognition of this, and the desire of the Indian and Alaska Native people to have greater control over their own destiny, Congress has recently passed two landmark laws affecting the Indian Health Program

Public Law 93-638, the Indian Self-Determination and Education Assistance Act, which relates to the activities of both the Indian Health Service and the Bureau of Indian Affairs, was enacted in 1975. The law strengthens and enhances the Indian Health Service's long-standing policy of giving Indian people maximum opportunity to become meaningfully involved in the programs serving them. Specifically, the law provides Indian tribes and Native groups with the option of managing and operating IHS programs in their communities, and authorizes assistance, if needed, for any tribe or group wanting to develop or improve their capabilities in order to take advantage of this option.

The other landmark law, the Indian Health Care Improvement Act, passed in 1976, is intended to elevate the health status of Indians and Alaska Natives to a level equal to that of the general population through a seven - year program of authorized higher resource levels in the IHS budget. Appropriated resources will be used to expand health services, build and renovate medical facilities, and step up the construction of safe drinking water and sanitary disposal facilities. Also established by the law, are programs designed to increase the number of Indian health professionals for Indian needs, and to improve health care access for the approximately half - million Indians living in urban areas of the country.

THE MISSION AND ORGANIZATION OF THE INDIAN HEALTH SERVICE

Mission

The IHS mission is to assure the availability of a comprehensive health service delivery system that will provide Indians and Alaska Natives opportunities for maximum involvement in defining and meeting their own health needs.

To achieve this, the Indian Health Service has established three main program objectives:

- Deliver the highest quality, comprehensive health services possible, including hospital and ambulatory medical care, preventive and rehabilitative services, and community environmental health programs, among them the construction of individual water and sanitation facilities.
- Assist tribes and Native corporations to develop their capacity to staff and manage health programs, and provide them with every opportunity to assume operational authority for programs, if they so choose.
- Act as the Indians' and Alaska Natives' Federal advocate in health-related matters.

In carrying out its mission, the Indian Health Service interacts with Federal and State agencies and other public and private institutions in developing ways to deliver health services, utilize manpower, stimulate consumer participation, and apply resources.

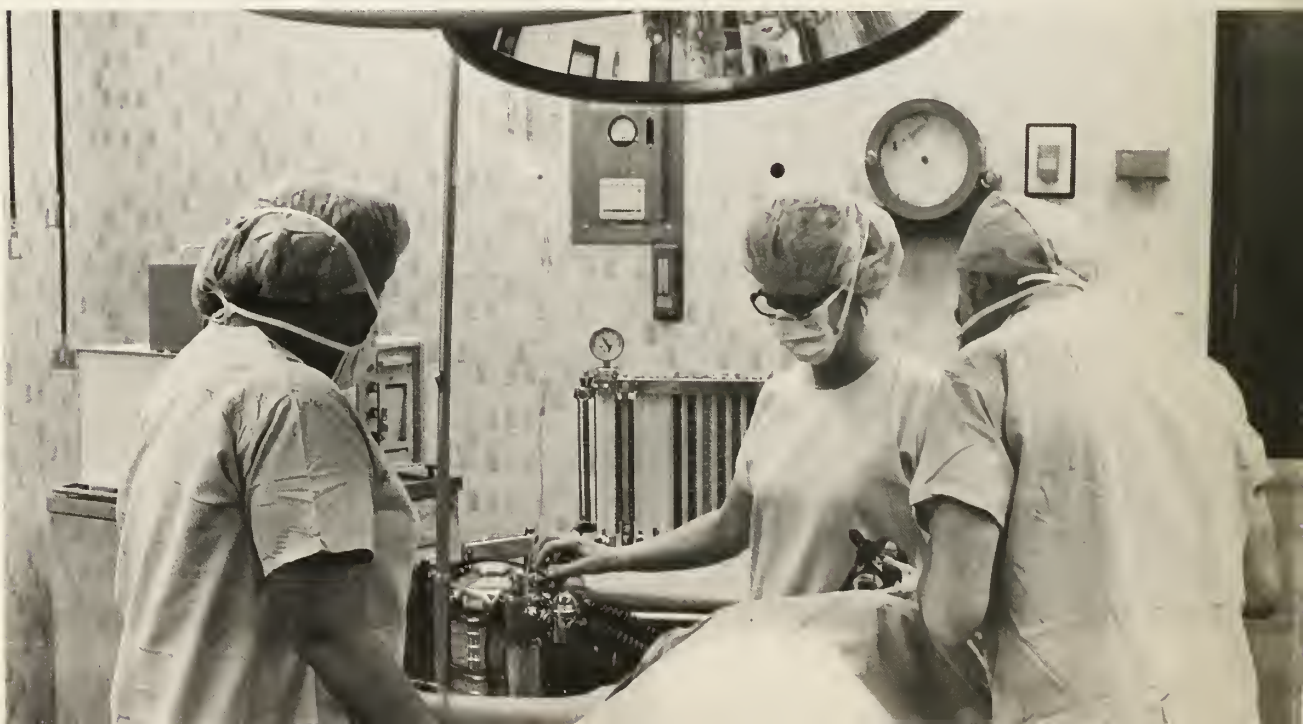
Organization

The principal role of the IHS headquarters staff is to coordinate and monitor field activities, prepare statistical information, and provide support for policy development, budget, program planning, implementation and evaluation, operation management, and community development.

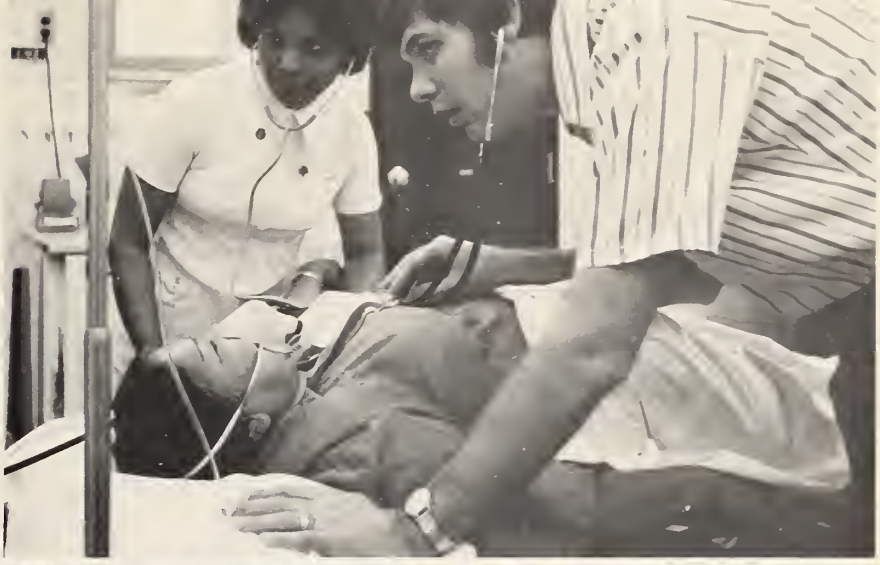
Field Administration

The Indian Health Service administratively is divided into eight *Area* and four *Program Offices,* one of which includes a research and development complex. Each Area and Program Office is responsible for operating the IHS program within its designated geographical area. The responsibilities of these field administrative offices include budget, operation, personnel and property management, program planning, implementation and evaluation, tribal affairs, community development, statistical information, grants and contracts management, and environmental health. Staff of Area and Program Office health services branches, such as nursing and dental health, work with corresponding staff at the services delivery level in IHS medical facilities and field services.

Delivery of health services at the local level is the responsibility of the *Service Unit,* the administrative subdivision of the Area and Program Office. There are 88 Service Units in the Indian Health Service; each covers a defined geographical area, usually centered around an Indian reservation or population concentration.



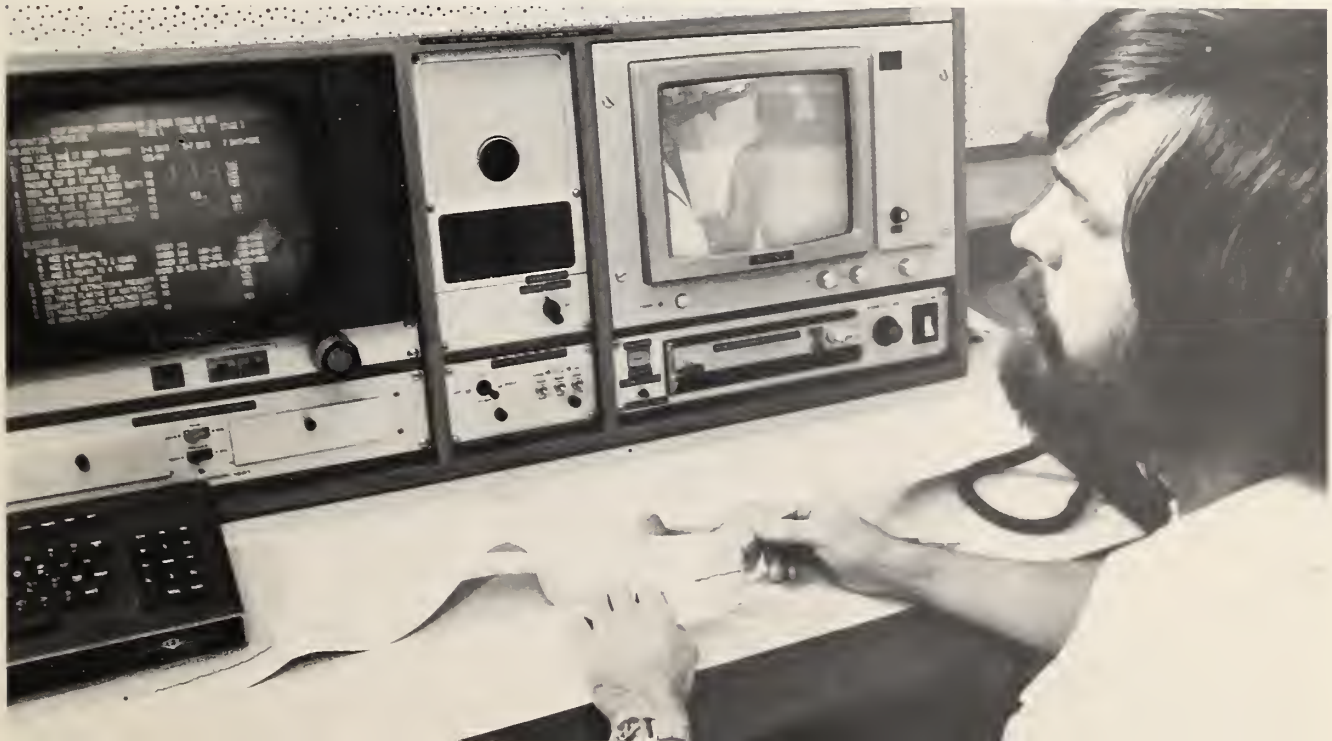
A few Service Units serve a number of small reservations, and conversely, some large reservations, such as that of the Navajo tribe, which covers 24,000 square miles and in fiscal year 1978 has a service population of 133,000, are served by several Service Units. These basic health service delivery components usually contain an IHS hospital or health center.



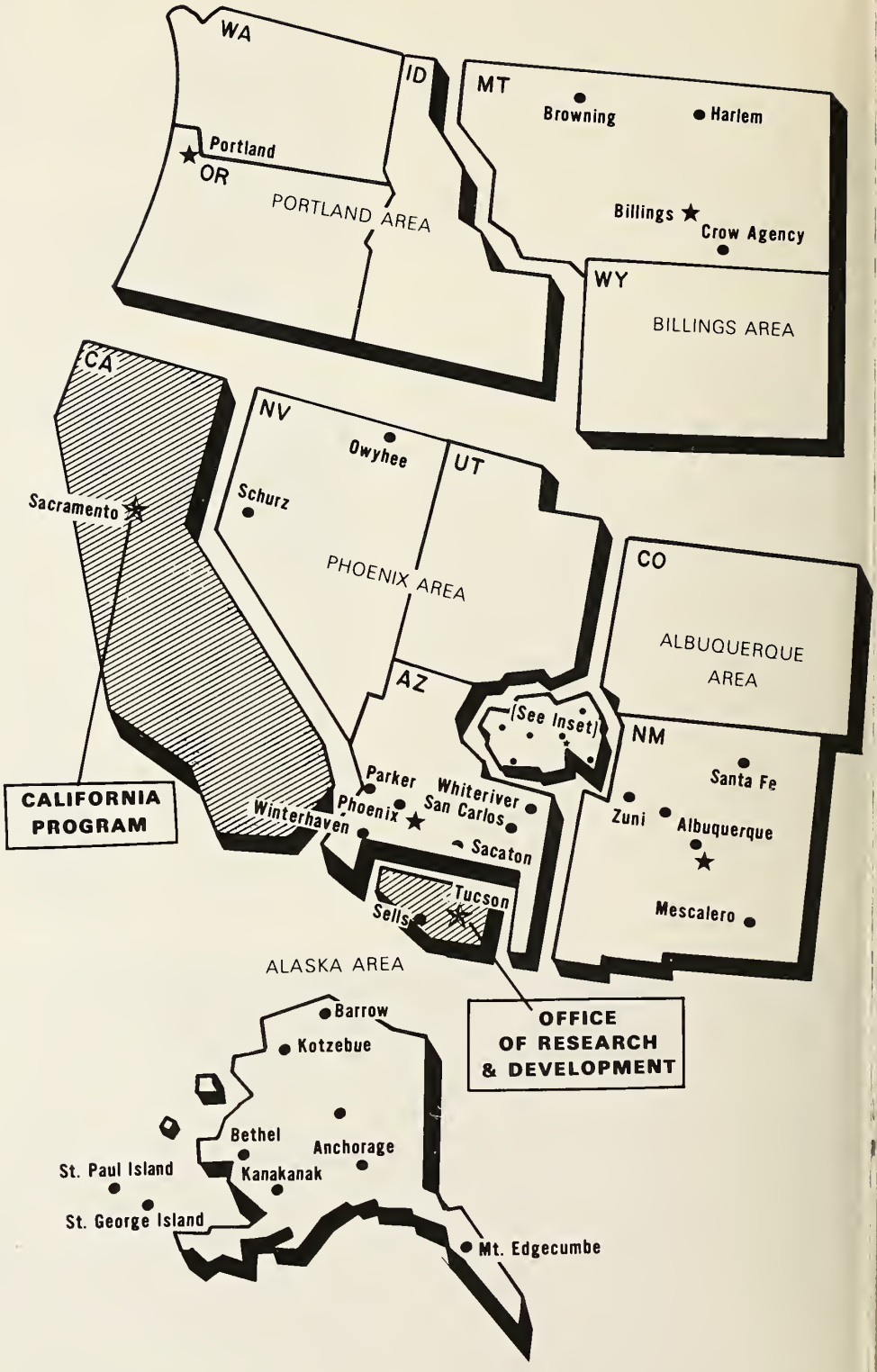
Research and Training

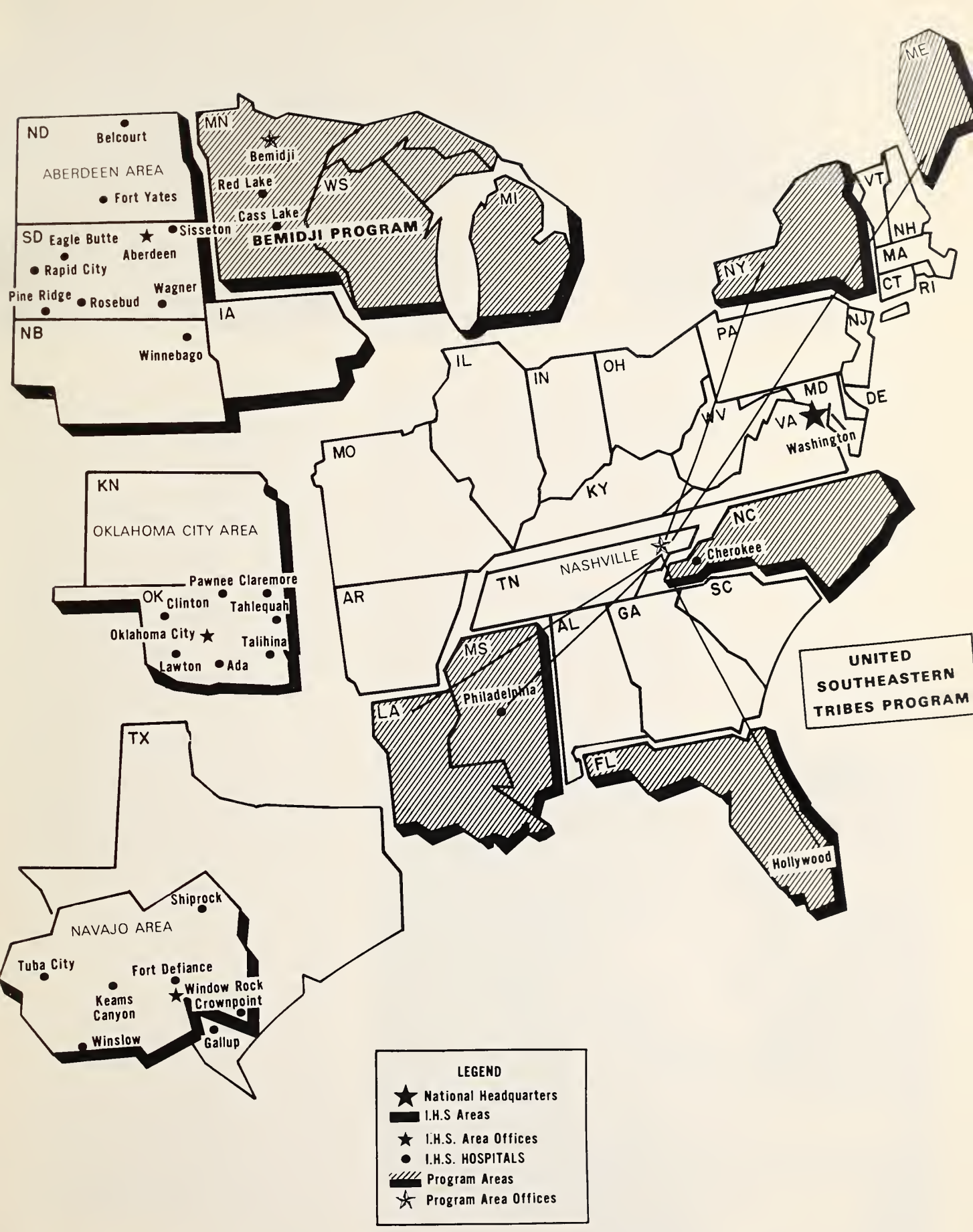
The Office of Research and Development (ORD) in Tucson, Arizona, combines the Indian Health Service's Training and Health Program Systems Centers and the Papago Reservation health program. A major function of ORD is to provide consultation and technical assistance to IHS management and health care delivery staff, and to tribal and Native groups in the evaluation, design, implementation and quality control of health management and services delivery systems. ORD is also responsible for developing and demonstrating new methods and techniques for Indian community involvement and coordinates health research and development activities within the Indian Health Program directed to the improvement of the health of the Indian people.

Training for IHS, tribal and Native group staff is designed to increase technical competency, and accelerate the transition of program decision-making from health professionals to Indian community leaders.



THE INDIAN HEALTH SERVICE

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THE INDIAN HEALTH SERVICE PROGRAM:

A COMPREHENSIVE APPROACH

Phoenix Indian Medical Center, Phoenix, Arizona.

The Indian Health Service operates a comprehensive health services program designed to meet the needs of the Indian and Alaska Native people. The program is planned and carried out in cooperation with Indian organizations at the national, regional and local levels, Federal, State and local agencies, educational institutions, professional societies, voluntary health associations, and others interested in improving Indian Health.

Indians and Alaska Natives served by the Indian Health Service receive a full range of preventive, primary medical (hospital and ambulatory), community health, and rehabilitative services. Secondary medical, highly specialized medical services, and rehabilitative care is provided by IHS staff, or through contract by non-IHS providers. Preventive health activities represent a cardinal focus of the IHS comprehensive health strategy. Emphasis is also placed on stimulating and enhancing Indian involvement. This includes expanding Indian manpower within the Indian Health Service in administrative and health service delivery professions, strengthening Indian influence in IHS policy formulation, and developing and improving tribes' and Native groups' abilities to manage and operate health programs.

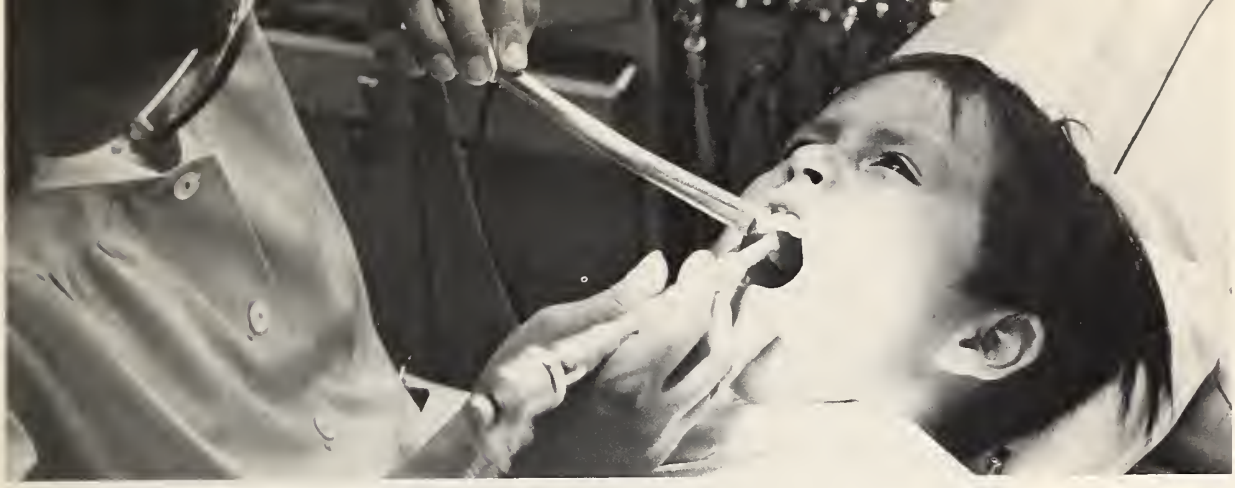
Health education has contributed to increased individual and community involvement in health matters.

The IHS program is community-oriented. The foundation of the program is a system of inpatient and ambulatory care facilities which the Indian Health Service operates on Indian reservations and in Indian and Alaska Native communities. The 51 IHS hospitals range in size from four to 181 beds. Three of these—in Phoenix, Gallup and Anchorage—also serve as referral, training and research centers. Also within this network of health care facilities are 99 health centers, including 23 school health centers, and more than 300 health stations and satellite field health clinics. Additional medical and dental clinics are held as needed.

In places where the Indian Health Service does not have its own facilities, or is not equipped to provide a particular service, it uses contract providers, such as hospitals, State and local health agencies, tribal health institutions, and individual health care providers. Services purchased through contract may include primary, secondary, and rehabilitative care, specialized diagnostic and therapeutic services, and public health and community outreach activities.

IHS direct and contract- provided services presently account for approximately 3,200,000 outpatient visits and about 110,000 hospital admissions annually, plus a wide array of community health services.

IHS Service Unit clinical staff includes physicians, dentists, nurses, pharmacists, laboratory and radiology technicians, and medical and dental assistants. Community health medics—IHS-trained physician assistants— nurse practitioners, and nurse midwives complete this clinical health care team, and many times serve in remote ambulatory care facilities. The clinical staff is supported by the work of medical records, engineering, housekeeping, maintenance, food service, supply, administrative and clerical personnel.



PREVENTIVE HEALTH SERVICES

Preventive health services are provided by clinical staff at IHS facilities, and by field health personnel, forming integrated health teams which work within the Indian community assisted by community health representatives and other tribal health workers. Preventive services include prenatal, postnatal and well-baby care, family planning, dental health, otitis media, diabetes, cardiovascular disease, trachoma, tuberculosis, immunization, environmental health activities, and health education. Among the programs involved in the integrated approach to preventive health are public health nursing, dental health, environmental health, and health education.

Public Health Nursing

The primary focus of the IHS public health nursing program is on the prevention of illness and the promotion and maintenance of health. Public health nurses are involved in planning and coordinating community health programs and services, determining health needs for the individual, the family, and the community, assessing health status, implementing health planning, evaluating health practices, and providing primary health care. In many of these endeavors the public health nurse works in close cooperation with other health personnel, especially community health representatives, maternal and child health aides and other indigenous auxiliary workers.

Public health nurses help prevent complications of pregnancy and improve the general health status of expectant Indian mothers and their infants by promoting early care in pregnancy; they aid in reducing infant morbidity and mortality through early visits to the newborn in their homes and by giving special attention to infants in high-risk families. IHS public health nurses also investigate the causes of communicable diseases through home visits, strengthen health teaching in the home, the community, and the clinical setting; provide counseling and guidance in health and family living to teenagers and young adults; and give immunizations to prevent infectious diseases in infants and children.

Dental Health

Dental program services are carried out in 180 IHS hospitals, health centers and other fixed facilities, and in 32 mobile dental units. In some locations, principally in Alaska, itinerant IHS dental teams travel to isolated villages with their equipment, often utilizing aircraft and even boats, where needed.

The dental program places priority on providing preventive and corrective dental care to children. Attention is also given to special groups such as preschool children,young mothers, the homebound and the handicapped.

Another aspect of the dental health program is fluoridation. To ensure that fluoridation equipment installed in Indian community water supply systems functions efficiently and safely, dental health staff work in close coordination with IHS environmental health program personnel and tribal workers.

Environmental Health

Environmental health services form an especially important part of the IHS preventive health approach because they attack the conditions which contribute to infectious diseases among Indians and the high morbidity and mortality rates of their infants. Some of these conditions are crowded, substandard housing, unsafe water supplies, and the lack of sanitary disposal facilities. The basic legislation for attacking the two latter conditions is Public Law 86-121, the Indian Sanitation Act, passed by

Tribal workers ensure the safe operation of water and sanitation facilities in the Indian community.

Congress in 1959. This law authorizes the construction and maintenance of water supply and waste disposal facilities for Indian homes and communities. Since its passage, the Indian Health Service had, through fiscal year 1978, initiated over 2,500 projects to provide Indian homes and communities with sanitation facilities. With the completion of all of these projects, 114,600 Indian homes—58,200 new or improved houses and 56,400 existing ones—will have been furnished with running water and safe disposal means. Much of this work has been done under cooperative agreements with the Department of Housing and Urban Development, the Bureau of Indian Affairs, the former Office of Economic Opportunity, and various Indian housing authorities.

Other projects initiated under Public Law 86-121 included engineering surveys, emergency construction, special projects, and training for tribal employees in the use, care and maintenance of constructed facilities. The Indian people have participated in these projects, contributing labor, material, and funds.

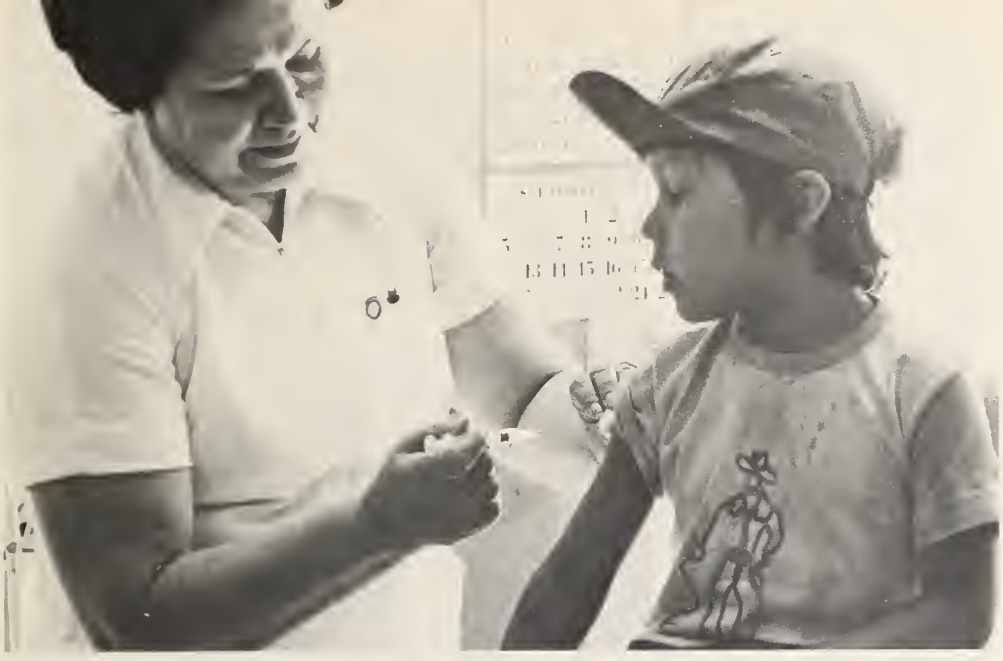
OTHER ENVIRONMENTAL HEALTH ACTIVITIES

The IHS environmental health program also includes comprehensive environmental planning, occupational health and safety, air, water and solid waste pollution control, and institutional environmental health programs in reservation areas. Program staff includes environmental engineers, sanitarians, environmental health technicians and sanitation aides. Other environmental health program activities encompass:

- Assisting tribes in the development and adoption of sanitary ordinances and codes.
- Participating in the investigation of communicable disease outbreaks and initiating corrective environmental control measures.
- Evaluating institutional facilities operated by the Bureau of Indian Affairs and the Public Health Service, and making recommendations to the operators of these facilities so that they may attain a healthful environment for Indians.
- Performing individual premise evaluations for the purpose of determining and eliminating environmental health deficiencies.
- Carrying out continuous evaluations of changing environmental conditions and planning jointly with Indian tribal officials in the development of comprehensive health programs.

Health Education

The IHS health education program is concerned with the organized approach to all educational deficiencies related to specific diseases as well as to health and safety hazards among Indians and Alaska Natives. The program is designed to assist them to assume greater individual, family and community responsibility in health matters through involvement and participation in community and health-related activities. Overall, the program attempts to increase their understanding of the nature of disease and how it can be reduced, to encourage a more discriminating use of health services, to develop Indian leadership in the assumption of responsibility for health matters and to involve more completely other agencies that have potentials for contributing to improve the health of the Indian population.



Significant strides have been made in improving children's health.

Special Health Concerns

Certain health-related problems are of special concern to Indian leaders and the Indian Health Service because of their impact on the Indian community. Among these are accidents, alcoholism, depression and other mental health problems, maternal and child health deficiencies, poor nutrition and the problems of the aging. Many of these problems are associated with social disorganization. The strategy to deal with these difficult problems is centered on comprehensive preventive measures and extensive community action and control.

ACCIDENTS

Accidents are the leading cause of death among Indians and Alaska Natives. In 1976, one out of every five deaths was the result of an accident. The 1976 age-adjusted death rate for accidents among Indians was 255 percent above that for All U.S. Races of 1975, and the ratio of Indian motor vehicle accident deaths for that year compared to that for the All U.S. Races in 1975 was 4.4. times as high.

Accidents, poisonings and violence are the second leading cause of hospitalization for general medical and surgical patients in IHS and contract hospitals—15,747 in fiscal year 1977. Patients admitted for these problems accounted for 14.8 percent of all hospitalizations.

To help combat this problem, IHS environmental health staff are working closely with Indian tribes, providing training and consultation in all aspects of home and community safety. Many tribes have set up injury and accident control programs in which specially trained community health representatives play a leading role in reducing or eliminating the causes of accidents. Community alcoholism programs also have a role in attacking the high rate of accidents among Indians and Alaska Natives.

MENTAL HEALTH

As the Indian and Alaska Native people have been caught more and more in the conflict between their traditional culture and the demands of modern society, mental health problems have increased. The seriousness of this problem is demonstrated by their 1974-1976 age-adjusted suicide rate which is 2.1 times as high as that of the 1975 U.S. All Races population, and by their homicide rate which is 2.5 times as high.

Emotional problems and behavior disorders are frequent among Indian children in their struggle for identity and achievement of self-sufficiency in a new social structure. There is an increasing need for mental health involvement in child guidance and counseling, and for the development of new and effective methods to prevent further trauma to the growing child.

Programs being developed throughout the Indian Health Service are aimed at helping the Indian person overcome cultural and linguistic barriers. Before the initiation of the IHS mental health program, Indian people in need of psychiatric care were often referred to psychiatrists and other professionals little acquainted with the realities of Indian life. The resulting encounters were often confusing and discouraging to both patient and psychiatrist.

The IHS mental health effort incorporates two essential requirements — a continuing effort to understand Indian life, ideas and language; and extensive Indian involvement in the program.

ALCOHOLISM

Alcoholism is one of the most serious challenges facing the Indian and Alaska Native people today. Its adverse effects are considerable; it is estimated that a majority of suicides, murders, accidental deaths and injuries among Indians are associated with excessive drinking, as are many cases of infection, cirrhosis and malnutrition. The alcoholism death rate among Indians and Alaska Natives rose between 1966 (30.3 per 100,000) and 1976 (48.8 per 100,000) by 61 percent. While the rate for the U.S. population as a whole has also increased, the Indian and Alaska Native rate has ranged from 4.3 to 6.2 times as high as that of the U.S. All Races category during these years. Over sixty-one percent (61.6) of the alcoholism deaths among Indians and Alaska Natives are the result of cirrhosis of the liver with mention of alcoholism; another 37.6 percent are the result of alcoholism, and the remainder is due to alcoholic psychoses.

The Indian Health Service, the National Institute of Alcohol Abuse and Alcoholism and the Indian people have worked together in the planning and development of a variety of community-level alcoholism prevention and control programs. Activities of the 153 programs now operating in Indian communities include half-way houses, referral services, counseling, and detoxification.

The responsibility for the administration and suppport of projects which have progressed beyond the developmental stage is now being assumed by the Indian Health Service from the National Institute of Alcohol Abuse and Alcoholism. To facilitate this transfer as well as provide a focal point for program emphasis on alcoholism as a priority health problem, the Indian Health Service has established a special Office of Alcoholism.

MATERNAL AND CHILD HEALTH

The high rate of morbidity and mortality among Indian infants in the first year of life is being met with emphasis on early prenatal care for the mother and continuing care after she and the baby leave the hospital. Health education activities are conducted to teach the mother proper ways to feed, bathe and care for her child within the often limited resources of her home, how to recognize illnesses, and why it is important to observe good health habits and make regular visits to the clinic.

The IHS nurse midwifery program has helped reduce maternal and infant deaths among Indians and Alaska Natives, especially among those living in the more remote and isolated areas. The program's objective is to improve prenatal, maternity and obstetrical services, make maternal and child health care more comprehensive in scope, make it more accessible to those in need, provide greater continuity of care, and free obstetricians to devote more time to complicated cases. Nurse midwifery programs have been instituted in Tuba City and Chinle in Arizona, and in the Shiprock and Gallup Service Units in New Mexico. Nurse midwifery services are also available at Pine Ridge and Rosebud in South Dakota. In addition, maternal and child health programs, initiated in cooperation with the Health Services Administration's Bureau of Community Health Services, the John Hopkins University and the University of Utah, help provide clinical experience for nurse midwives in Shiprock, New Mexico and Fort Defiance, Arizona.

Family planning services to protect the health of mothers and promote a healthy and happy family environment are another element of the comprehensive program. Family planning activities were intensified in 1965. In fiscal year 1977, 29 percent of the almost 99,000 Indian and Alaska Native women between the ages of 18 to 44 years served by the Indian Health Service were rendered family planning assistance, including counselling, fertility and contraceptive services.

OTITIS MEDIA

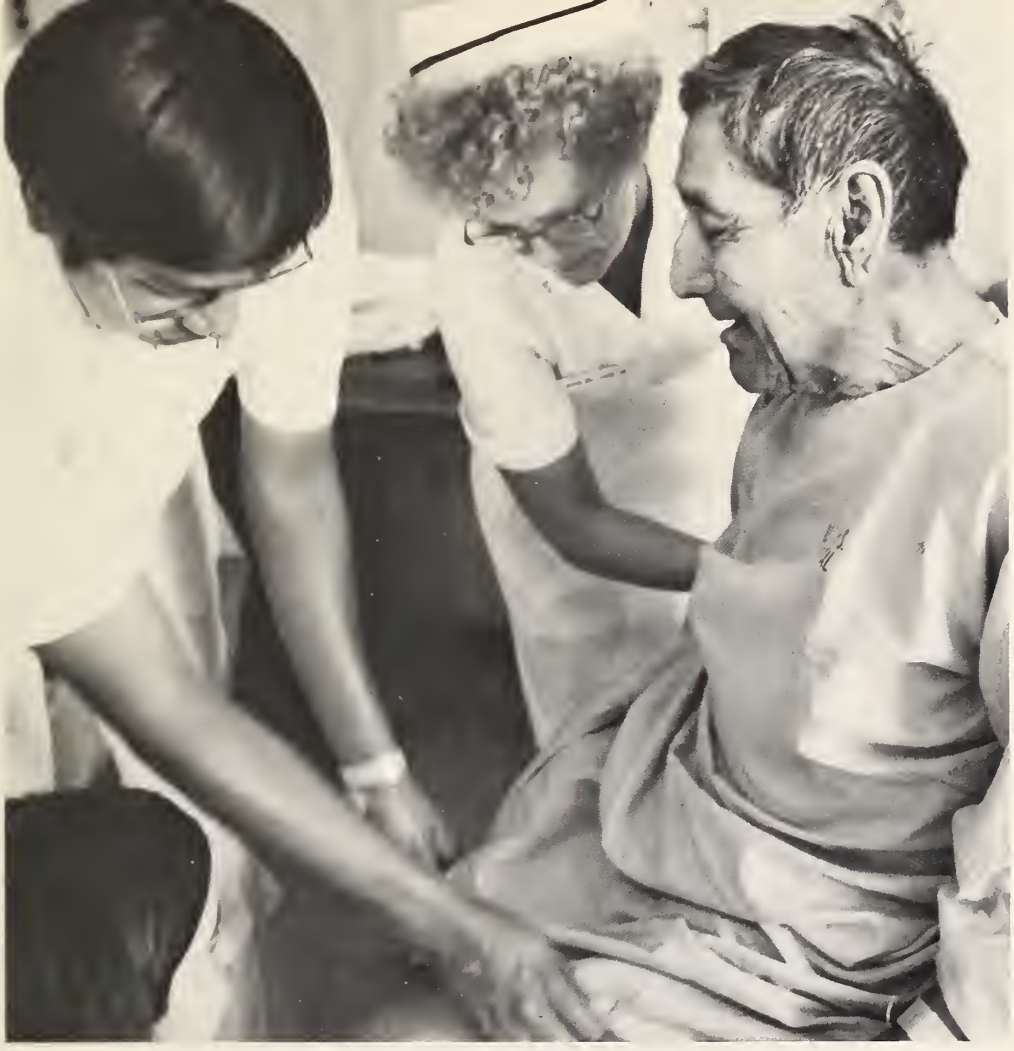
Otitis media, a disease of the middle ear, replaced tuberculosis as the Indians' major health problem prior to fiscal year 1971, when the IHS otitis media program was initiated with special funding from Congress. Since then, the greatest success has been registered in Alaska where the chronic otitis media rate has been significantly reduced due to the more than 3,600 surgical procedures undertaken there.

With the availability of additional funds and personnel, other programs similar to that in Alaska will be undertaken to expand preventive efforts, step up casefinding and treatment of acute otitis media, intensify the treatment of chronic otitis media and the correction of its complications, and expand rehabilitative measures.

NUTRITION

Poor nutrition is a contributing or complicating factor in many health problems of Indian and Alaska Native people. For those considered at nutritional risk—infants, preschool children, adolescents, pregnant and lactating women, the elderly, and the chronically ill—sound nutrition is essential.

In the IHS program, nutritional care is an integral part of health services delivery. Emphasis is placed on incorporating nutrition education into every health, social and education service and food assistance program available to Indians and Alaska Natives.



Increasing attention is being focused on the needs of the elderly by IHS and tribal health planners.

The nutrition and dietetics program includes preventive and direct patient care nutrition services; operation of the dietary departments in IHS hospitals; training and career development for Indians in food service and community nutrition; advocating the improvement of the quantity and nutritional quality of the Indians' food supply; and in-service education and training in nutrition for IHS staff.

AGING

Life expectancy at birth for American Indians and Alaska Natives has increased from 60.0 years in 1950 to 65.1 years in 1970. The number of Native Americans over 45 years of age has increased as well. This in turn has created a greater demand for health and social services for ambulatory, home-bound and institutionalized aging and aged persons.

The Indian Health Service, in response, is placing special attention on health assessments, with timely follow-up to prevent unnecessary illness and disability. At the same time, services are being expanded in areas of primary concern to the elderly, for example, diabetes and arthritis. The reduction of disability due to accidents is being addressed also, as is the need for home repairs and other special environmental improvements for comfort and safety.

To deal more comprehensively with the problems of its elderly service population, each IHS Area is developing detailed health profiles on the aging — persons 45 - 54 years of age — and the aged — persons 55 years of age and over.* The information gathered will be available for tribal and IHS-wide planning activities as well as for program and policy development leading to the establishment, by 1980, of an identifiable geriatrics program in those Areas with the largest aging and aged populations. IHS policies related to the provision of long-term care are being reviewed, and tribal sponsorship of institutional and home care programs is being encouraged. Technical assistance is being provided by IHS staff, particularly by members of the IHS Committee on Aging, to tribes and Indian organizations concerned with developing new services and facilities for the elderly.

*Age limits used by National Indian Council on Aging.

Many kinds of human skills are needed by the Indian Health Service in carrying out its mission. The two avenues for obtaining these are recruitment and career development activities. Staff education, training and structured assignments for IHS employees are vehicles for improving program management, providing skills for special needs, promoting employee career development, and improving the effectiveness of consumer participation. Training opportunities through the Indian Health Program are also available to Indian and Alaska Native advisory health board members and tribal and corporation health program management staff and health services workers.

The Indian Health Service offers career opportunities in a wide range of professional health, allied health, administrative and other fields under the Federal Civil Service and U.S. Public Health Service Commissioned Corps personnel systems. Opportunity for choice of practice site exists for physicians, dentists, nurses and other health professionals.

A policy of Indian preference is followed in recruitment and career development training. Currently,more than half of the health care staff is of Indian or Alaska Native descent. Many of these, in addition to their regular duties, provide valuable interpretive, educational and motivational services.

Professional Education and Training

Education, training and career development opportunities for IHS professional staff include: specialty training in public health leading to a master of public health degree for physicians, dentists, nurses, and others; physician residency training in pediatrics, surgery, obstetrics-gynecology, and preventive medicine; a dental residency program; and a pharmacy internship. Pharmacists also have the opportunity for expanded-role training in health care delivery through a unique training program at the PHS Indian Medical Center in Phoenix, Arizona. Training in various nursing specialty fields, including anesthesia, is available for IHS nurses.

In addition, professional staff members have opportunities to study subjects such as epidemiology, program planning, and managerial practices at the IHS Training Center in Tucson, Arizona and other locations.

Nursing Careers for Indians and Alaska Natives

Indians and Alaska Natives are among the most under-represented of any group in the health professions field, and consequently, the number available for work in the Indian community is low. Authorizations contained in the recently-implemented Title I of the Indian Health Care Improvement Act seek to change this, but the impact on health care will not be immediately felt.

One health professions field in the Indian Health Service in which Indians have made notable strides in recent years is nursing. Today approximately a fourth of its 1700 professional nurses are of Indian or Alaska Native descent. These strides have been made through the efforts of the nursing program which has placed emphasis on seeking to recruit Indian nurses. The Indian Health Service also supports nursing education programs that are designed to provide Indian employees with the opportunity to obtain an associate degree in nursing. These programs are in Phoenix, Arizona and Aberdeen, South Dakota. Another IHS-supported program, in Albuquerque, New Mexico, offers a choice of associate or baccalaureate degree for Indian registered nurses to enhance their ability to compete for community health and nursing administration positions within the Indian Health Service.

Costep

The Indian Health Service participates in COSTEP (Commissioned Officers Student Training Extern Program), which offers health professions students an opportunity to gain experience within the health program environment. A limited number of students are commissioned as reserve officers in the Public Health Service Commissioned Corps and are called to active duty during free periods of the academic year. These officers can serve in any of the IHS facilities or programs. Many students who participate in this program subsequently enter career service in the Indian Health Service.

Work Study Programs

Work study and cooperative educational arrangements have been developed with many high schools, colleges and universities to encourage Indian students to study for health careers while working in their home communities. Counseling programs have also been established at high schools and colleges to identify and place Indian students in health programs.

Medical laboratory technician training is available in Gallup, New Mexico and Tsaile, Arizona.

Allied Health and Auxiliary Personnel Training

Allied and auxiliary health personnel of the Indian Health Service, tribes and Native corporations play a vital role in the Indian Health Program. By supplementing the work of health professionals, they help make health services more accessible and comprehensive, strengthen continuity, and increase Indian involvement in health activities. The Indian Health Service offers training in a number of allied health and auxiliary fields for IHS and tribal employees. Training activities have been greatly expanded in recent years.

Among the careers for which training is provided are: community health medic (physician assistant), community health representative, community health aide, medical laboratory technician, audiometric technician, health records technician, environmental health technician, dental assistant, mental health worker, medical social work associate, food service supervisor, and nutrition aide. On-the-job training is provided for such positions as nursing assistant, food service worker, and medical records clerk.

COMMUNITY HEALTH MEDIC (PHYSICIAN ASSISTANT)

The community health medic (CHM) is a physician assistant specially trained for the unique challenges of Indian health. The CHM provides primary care services under physician supervision. Many serve directly under a physician in a hospital outpatient department or in a health center. Others sometimes are used to extend primary health care services to remote locations where there may be no full-time physician.

Another function of the CHM is to assist in the conduct of the local community health program. The CHM is knowledgeable about the culture of the Indian people he serves and often belongs to the same tribe. By providing routine ambulatory health care services, the CHM frees the physician to devote more time to complicated medical cases.

The American Medical Association-approved CHM training program is divided into one year of classroom study and clinical experience at the Gallup Indian Medical Center in Gallup, New Mexico, and another year of preceptorship at the CHM's home Service Unit. CHM trainees may earn up to 72 college credit hours while studying. More than 100 CHM's have been trained by the Indian Health Service since the program was initiated in 1971.

COMMUNITY HEALTH REPRESENTATIVE

Community Health Representatives (CHR's) are Indian people, selected, employed, and supervised by their tribes and trained to meet specific tribal needs.

CHR's receive training at the Indian Health Service Training Center in Tucson, Arizona, and at other training facilities. The curriculum includes classroom study and field experience under the supervision of professional medical and health personnel. CHR's learn the concepts of health and disease, basic health skills, home nursing, first aid, nutrition, health education, and environmental health. Principles of communication, group organization, and planning as well as conducting meetings are also taught. Almost 1,800 CHR's are now providing services to their people. The CHR program is designed to improve communications between the Indian community and providers of health services as well as increase basic health care and instruction in Indian homes and communities.

COMMUNITY HEALTH AIDE

The Community Health Aide (CHA) training program was developed to provide an on-the-scene health resource for people in remote, inaccessible villages in Alaska. This training emphasizes skills which enable the aide to deliver a wide range of medical services under professional supervision from Alaska Native hospitals. The CHA is often the only person with health training residing in the village. They also serve to stimulate community health activities, promote local participation in health programs, locate new health resources and devise innovative ways of using them. More than 300 Alaska Native CHA's, representing 200 villages, have been trained.

MEDICAL LABORATORY TECHNICIAN

As part of its laboratory improvement program, the Indian Health Service conducts a two-year program to train medical laboratory technicians for its facilities. Training is conducted at the Navajo Community College in Tsaile, Arizona, and at the Public Health Service Gallup Indian Medical Center in Gallup, New Mexico.

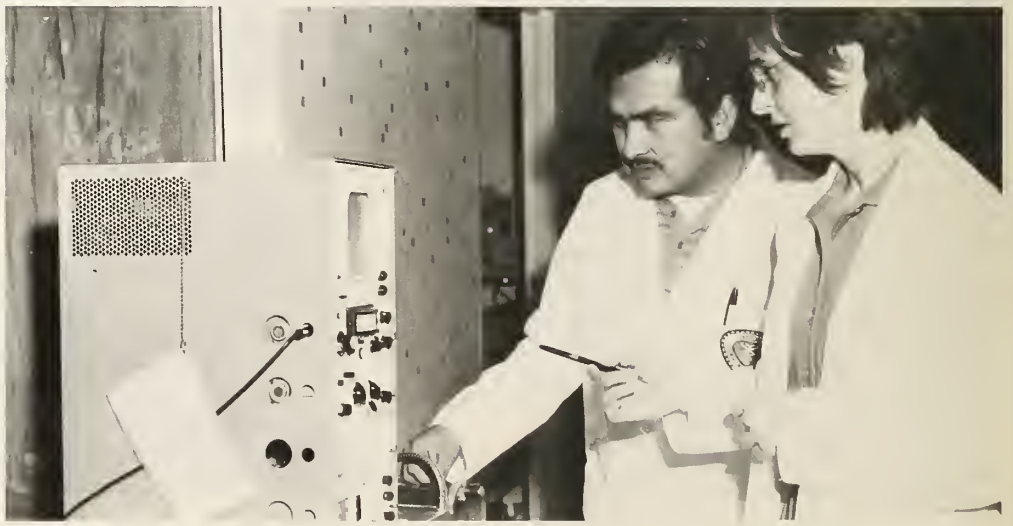
AUDIOMETRIC TECHNICIAN

Started in 1972, this program trains audiometric technicians for work in the Indian Health Program. Other IHS personnel, such as public health nurses, social workers, hospital clerks and otitis media program assistants, as well as tribal community health representatives who specialize in services to the hearing-impaired, also receive training in audiometry and/or impedence testing.

The basic course lasts two weeks and is generally held at the Indian Health Service Communications Disorders Unit in Albuquerque, New Mexico. Additional one-week sessions on impedence audiometry and advanced courses for those desiring review and/or in-depth study of communications disorders are also provided. The program has recently been expanded to include an emphasis on otology for IHS clinical personnel.

HEALTH RECORDS TECHNICIAN

Career opportunities for young Indian men and women in the health records field are available through an accredited two-year program of academic study at approved junior colleges. Sponsored in conjunction with the Bureau of Indian Affairs and the college, this open-end training which can lead to a baccalaureate degree, has been developed to help meet the shortage of health record librarians in Indian hospitals.



More than 100 community health medics have been trained by the Indian Health Service since 1971.

ENVIRONMENTAL HEALTH TECHNICIAN

Training in the basic elements of communicable disease transmission, sanitary practices, and health education techniques is available to Indians who wish to work in environmental health. Following completion of training, the individual is assigned to work on the reservation with Indian people. Basic and advanced courses are given each year with the latter adjusted to provide staff competencies needed for program operations.

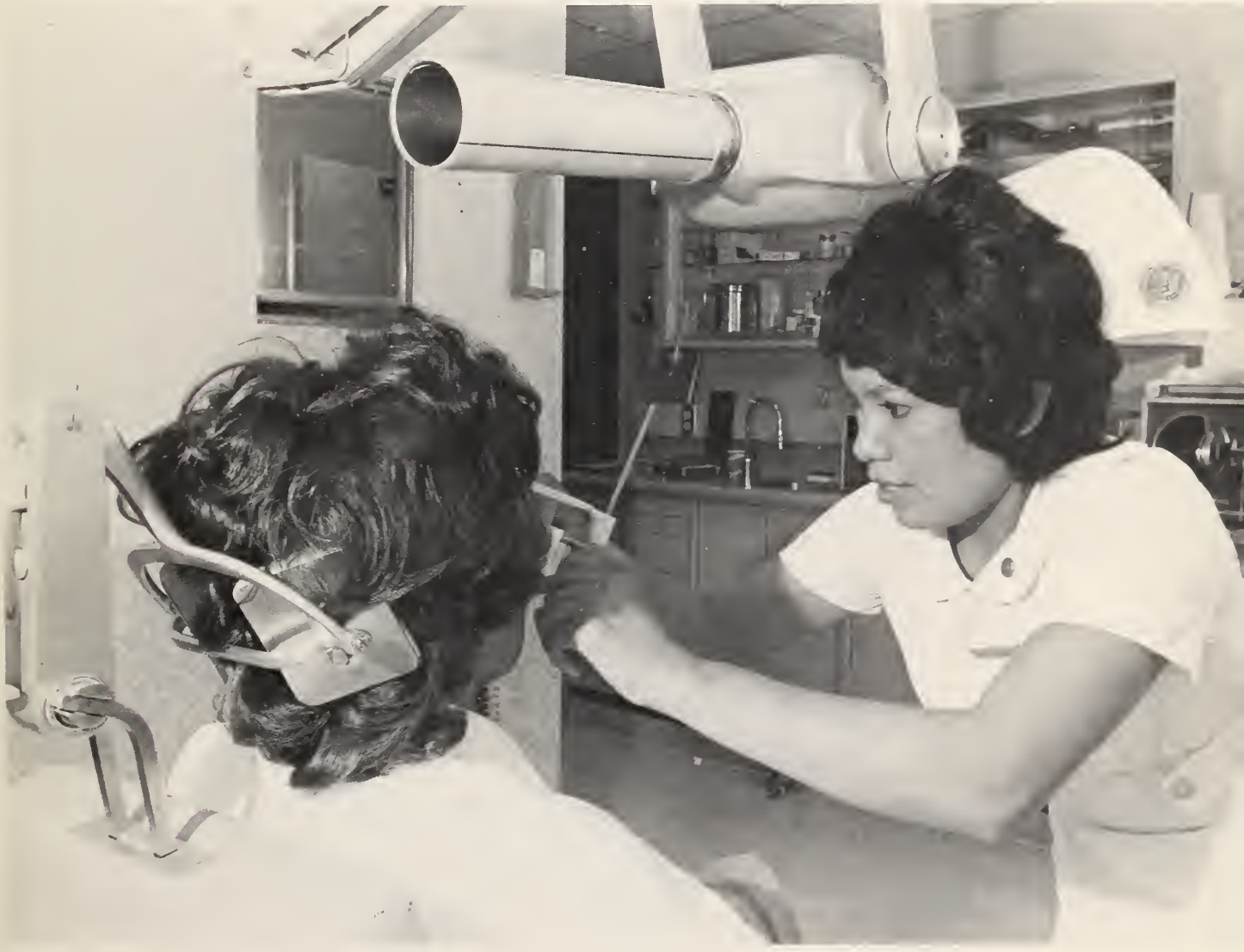
Short-term training is provided to strengthen and expand the environmental health technician's responsibilities in community environmental health practices, such as epidemiology, water supply, waste disposal, institutional sanitation, occupational health and community injury control, as well as managerial aspects of environmental health programs.

DENTAL ASSISTANT

One-year programs in Indian schools located in Albuquerque, New Mexico, Lawrence, Kansas, and Mt. Edgecumbe, Alaska, train Indian and Alaska Native high school graduates to be dental assistants. Students are trained in chairside assisting, preventive services, efficient dental practice management and expanded duties. The three training programs are accredited by the American Dental Association. Graduating dental assistants are eligible for certification after taking the required examination.

Approximately 40 dental assistants are graduated from these three programs each year and most are subsequently employed at various IHS dental facilities. These Indian and Alaska Native dental assistants contribute significantly to the IHS dental program, increasing dental team-provided services by more than 30 percent.

The Indian Health Service's three dental assistant training programs are accredited by the American Dental Association.



Career preparation in the health records field is offered through a two-year program of academic study at approved junior colleges.

MENTAL HEALTH WORKER

The mental health workers is an essential member of the IHS mental health team. Mental health workers are Indians or Alaska Natives who are knowledgeable about the psychological and social make up of the people they serve. Appreciating Indian attitudes toward health and illness, such workers are highly sensitive to the needs of the community in which they work. As such, the mental health worker is instrumental in facilitating communication between the Indian patient and the non-Indian medical provider, and acceptance of mental health activities by the Indian community.

Mental health workers are trained to assist psychiatrists, psychologists, psychiatric social workers and other mental health professionals in providing therapy services in the Indian community, in schools, and in hospitals and health centers.

Training consists of study and closely supervised tutelage by mental health professionals in an environment familiar to the mental health worker trainee—usually his own community. As the mental health worker gains experience and knowledge in professional methods, he is given greater independent responsibility to work as a member of the total health team.

MEDICAL SOCIAL WORK ASSOCIATE

A two-year program consisting of on-the-job training as well as formal education is conducted to prepare Indians and Alaska Natives as medical social work associates with the Indian Health Service. Medical social work associates augment the professional medical and mental health social staff, serving patients, families, and communities. In addition to providing applied and practical services, the worker assists patients in obtaining all available medical services. In remote and inaccessible areas, the associate medical social worker often works without direct supervision.

NUTRITION AND DIETETICS

As a result of increased national interest in nutrition and nutrition-related problems, and the plans developed to implement recent legislation, the Indian Health Service is expanding nutrition training for both IHS and tribal employees. Relatively newly established tribal food and nutrition programs such as: Day Care; Headstart; Women, Infants, and Children (WIC); Supplemental Food Program; Group Care Facilities and Half-Way Houses; Rehabilitation Centers; Nursing Homes; Senior Citizen Centers; and Food Assistance Programs have increased the need for trained nutrition personnel. To meet these additional needs, the N & D program has increased opportunities by offering a variety of short-tern courses, and planning in cooperation with a community college for the development of an American Dietetic Association-approved program for supportive personnel. Training courses are offered at the Food Service Training Center in Santa Fe, New Mexico, and the Nutrition Training Center in Tucson, Arizona. The goals of the nutrition and dietetics training programs are to improve the quality of nutritional care services and to offer career development opportunities for American Indians and Alaska Natives.

Tribal Leadership Training

The Indian Health Service sponsors and encourages leadership training for Indians serving on local and Area health boards, the National Indian Health Board, and in other tribal capacities. Emphasis on this training has increased over the years as more and more Indians have become actively involved in the management of their health affairs. Training programs are conducted at local, area, and national levels, and include management and supervision, personnel development, financial and budget management, computer services, and other subjects needed to meet stated tribal and community needs.

THE ROLE OF THE AMERICAN INDIAN AND ALASKA NATIVE PEOPLE

Over the past decade, tribally established community health boards, representing the tribes served by IHS Service Units, have helped develop local program policy, determine needs and priorities, and allocate resources. Area Indian health advisory boards, composed of representatives of the community health boards within each IHS Area, perform similar functions. The Area boards are in turn represented by the National Indian Health Board, Inc., in Denver, Colorado, which together with other organizations such as the National Tribal Chairmen's Association and National Congress of American Indians, works directly with the Indian Health Service at the national level.

Indian involvement in program implementation is another important part of the Indian Health Program. From the start it was recognized that community involvement was essential to the treatment, prevention, and control of unfavorable health conditions, and should be made an integral part of the program. As the Indian Health Program expanded, elements of local community involvement were built into program implementation. In 1971, a Division of Indian Community Development was established in the Indian Health Service to help in this effort.

Today a growing number of tribes and Native corporations are being provided technical assistance to help them develop or strengthen institutions such as health boards and health departments, and to train their staffs in administrative and management skills. This activity has been expanded with the passage of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, in 1975. Urban Indian health projects in a number of cities also receive IHS technical assistance. Title V of the Indian Health Care Improvement Act, passed in 1976, allows for expansion of IHS assistance to urban Indian projects.

The scope of program activities managed by tribes and Native corporations is wide. It includes community health, mental health, alcoholism and accident prevention services, as well as activities such as program planning and evaluation, training, and the planning, construction and operation of health facilities. Large-scale examples of Indian organizations involved in the implementation of IHS program activities are the California Rural Indian Health Board and United Southeastern Tribes, both of which deliver a variety of health services to Indian populations in wide geographic areas.

The Indian Health Service is also the Indian and Alaska Native people's advocate in health-related matters, and as such, helps them to identify and seek out Federal resources applicable to their health, social and economic problems.

Tribal organizations play a vital role in determining health needs and resources to meet them.

Indian Sanatorium, Phoenix, Arizona, circa 1920.

The History of the Indian Health Program

Health services for American Indians began in the early 1800's when Army physicians took steps to curb smallpox and other contagious diseases in Indian tribes living in the vicinity of military posts. Treaties committing the Federal Government to provide health services were introduced in 1832, when a group of Winnebagos was promised physician care as partial payment for rights and property ceded to the Government. Of almost 400 treaties negotiated with Indian tribes from 1778 to 1871, about two dozen provided for some kind of medical service. Although most treaties imposed time limits of five to 20 years for provision of care, the Federal Government adopted a policy of continuing services after the original benefit period expired.

Transfer of the Bureau of Indian Affairs from the War Department to the Department of the Interior in 1849, stimulated the extension of physicians' services to Indians by emphasizing non-military aspects of Indian administration and by developing a corps of civilian field employees. Within 25 years, about half of the Indian agencies had a physician, and by 1900 the Indian Medical Service employed 83 physicians, including those giving part-time services.

Nurses were added to the staff in the 1890's and grew from eight in 1895 to 25 to 1900, with practically all of them assigned to Indian boarding schools. Beginning in 1891, field matrons were employed to teach sanitation and hygiene, provide emergency nursing service, and prescribe medicine for minor illnesses, activities which were later taken over by public health nurses.

Indian Bureau policy by the late 1880's clearly directed physicians to promote preventive activities, but efforts were limited until well after the turn of the century due to the pressure of curative work.

The first Federal hospital built for Indians was constructed in the 1880's in Oklahoma and a concentrated movement was underway before 1900 to establish hospitals and infirmaries on every reservation and at every boarding school. The reasons for construction were the isolation in which Indians lived, the lack of nearby facilities, and home conditions which made prescribing a course of treatment outside a hospital often useless and sometimes dangerous to the patient.

Professional medical supervision of Indian health activities was begun in 1908 with the establishment of the position of chief medical supervisor, and was strengthened in the 1920's by the creation of the Health Division and appointment of district medical directors. The first appropriation earmarked specifically for general health services to Indians was made in 1911. In 1926, medical officers of the Public Health Service Commissioned Corps were detailed to certain positions in the program.

Individual disease control programs, such as tuberculosis, were begun early in the 1900's, and health education activities to support these programs were introduced in 1910.

Assessing home conditions on the reservation, early 1940's.

Dental services were organized in 1913 with the assignment of five itinerant dentists to visit reservations and schools.

Pharmacy services were organized in 1953 with PHS pharmacy officers assigned to headquarters, Area offices, and hospitals to develop and institute dispensing, packaging, and distribution policies and practices.

Until the late 1920's sanitation services did not extend beyond occasional "clean-up" campaigns and physicians' inspections of homes, schools, and Indian agencies. In 1928, sanitary engineers of the Public Health Service began assistance to the Bureau of Indian Affairs in surveying water and sanitation systems and investigating other basic sanitation problems, usually restricted to Bureau installations. An expanded program to improve sanitation in individual homes was begun in 1950.

In 1955, Congress transferred responsibility for Indian health from the Department of the Interior to the Public Health Service. At the time both medical facilities and personnel were inadequate to meet the Indians' health needs.

The initial program priorities for the Public Health Service's new Division of Indian Health were to assemble a competent health staff; establish adequate facilities where services could be provided; institute extensive curative treatment for the many Indians who were seriously ill; and develop and initiate a full-scale preventive program which would reduce the excessive amounts of illnesses and early deaths, especially from preventable diseases.

Since that time, the Division of Indian Health, now the Indian Health Service, has assumed more responsibilities and has expanded its staff from a small corps of health professionals to over 9,000 skilled and dedicated men and women. The number of physicians in the program has risen from 125 to 600, dentists from 40 to 256, and registered nurses from 780 to 1700. To its original health staff of clinical physicians, dentists, clinical nurses, pharmacists and sanitary engineers, the program has added field health physicians, medical record librarians, public health nurses, community health medics and aides, practical nurses, dental assistants, maternal and child health specialists, environmental sanitarians, and auxiliaries in a number of categories.

Since 1955, 20 hospitals, 21 health centers and 58 field health stations have been built, and major alterations have been made at 11 other facilities. Through Public Law 85-151, 165 beds to serve Indians and Alaska Natives have been added in 20 community hospitals which were constructed with Hill-Burton assistance.

Additionally, the capabilities of the Indian Health staff have been expanded through numerous education and training activities designed to increase efficiency, augment manpower resources, and promote career development.

Dramatic increases in the use of services have occurred since 1955. Virtually all Indian births (97.8 percent in 1976) occur in hospitals today. Annual admissions to Indian Health Service and contract hospitals have more than doubled; outpatient visits made to hospitals, health centers, and field clinics have increased 7.1 times; and the number of dental services provided is 5.8 times as great.

Another development since 1955 is that many Indian tribes and inter-tribal organizations are now managing and operating Indian Health Service programs and services in their communities. While providing Indian people the opportunity to become involved in the shaping and administration of their own health affairs has always been a program objective, other pressing needs kept the Indian Health Service from turning its optimal attention to this need in the early years. Recent legislation in the form of the Indian Self-Determination and Education Assistance Act and increased funding through the Indian Health Care Improvement Act promise to further assist tribes desiring to assume responsibility for their health programs.

Health levels among American Indians and Alaska Natives have substantially improved. From 1955 to 1976 infant death rates have declined from 62.5 to 19.1 per 1,000 live births; tuberculosis death rates are down 86 percent; gastroenteric death rates are down 86 percent, and death rates from influenza and pneumonia are down 59 percent.

Tuberculosis, once the number one scourge of Indians and Alaska Natives, has been dramatically contained. In 1956 for example, the Indian Health Service had 3,606 tuberculosis admissions to PHS Indian and contract hospitals. In fiscal year 1977, there were only 194 tuberculosis admissions. This represents a decline of 95 percent in tuberculosis hospital admissions.

New active case rates of tuberculosis among Indians and Alaska Natives also have been dramatically reduced. Fiscal year 1976 figures show that they are down 73 percent since 1962.

In addition, life expectancy at birth for Indians and Alaska Natives in 1970 was 65 years, as compared to 71 years for the general population. In 1950 the Indian life expectancy was 60 years and that of the general population, 68 years—both populations can expect to live longer now than they could have in 1950.

There are other manifestations of better general health reflected in a leveling off of hospitalizations and a continuing large increase in clinic visits, signifying less severe illnesses and fewer people requiring prolonged hospital care. These changes indicate a stabilization of therapeutic health activities and the growing acceptance of health maintenance measures by Indians and Alaska Natives.

Age of the Population

According to the 1970 Decennial Census, the median age of Indians and Alaska Natives served by the Indian Health Service was 18.6 as compared with a median age of 28.1 years for the U.S. population as a whole. Recent census age data indicate that there has been a slight change in the age structure of the total U.S. population. The median age of the U.S. population was estimated to be 29.0 years as of July 1, 1976. This is a rise of almost one year over the 1970 figure. Similar changes have also occurred in the median ages of the population for several racial groups. In 1977, age data are not available for Indians but from the changes in the other racial groups, it is felt that the Indian median age has also risen slightly.

VITAL EVENTS

BIRTH RATES (LIVE BIRTHS PER 1,000 POPULATION) 1976 (CALENDAR YEAR).

Indian and Alaska Native 30.7
U.S. All Races 14.7

Indian and Alaska Native birth rates, after steadily increasing from 1955 through 1964, have declined since 1965. The birth rate in 1955 was 37.1 per 1,000 population, reaching its peak in 1964 with a rate of 43.3. In 1976 the Indian and Alaska Native birth rate was about twice that for the U.S. All Races.

INFANT DEATH RATES PER 1,000 LIVE BIRTHS, 1976 (CALENDAR YEAR).

Indian and Alaska Native 19.1
U.S. All Races 15.1

The Indian and Alaska Native infant death rate has declined about 69 percent since 1955, and is now 1.3 times as high as that of the general population.

NEONATAL DEATH RATE PER 1,000 LIVE BIRTHS, 1976 (CALENDAR YEAR).

Indian and Alaska Native 9.0
U.S. All Races 10.8

The death rate among Indian and Alaska Native infants under 28 days of age (the neonatal rate) has declined about 60 percent since 1955 and is now lower than that for the general population. In calendar year 1976, 97.8 percent of Indian and Alaska Native births occurred in hospitals. This closely approaches the U.S. proportion of 98.7 percent of all births occurring in hospitals in 1975. Major causes of neonatal deaths include immaturity, respiratory distress syndrome, asphyxia of the newborn, congenital anomalies, and hayline membrane disease.

POST NEONATAL DEATH RATES PER 1,000 LIVE BIRTHS, 1976 (CALENDAR YEAR).

Indian and Alaska Native 10.1
U.S. All Races 4.3

The death rate among Indian and Alaska Native infants 28 days through 11 months of age since 1955 has been reduced by 75 percent, but is still more than two times higher than in the general population. In 1968 the Indian and Alaska Native rate (16.5) was almost three times as high as the rate for the general population (5.7). The chief causes of post-neonatal deaths are symptoms and ill-defined conditions, pneumonia, congenital anomalies, accidents, diarrheal diseases, and meningitis.

LEADING CAUSES OF DEATH, 1976 (CALENDAR YEAR)

Leading causes of death amont Indians and Alaska Natives were accidents, diseases of the heart, malignant neoplasms, cirrhosis of the liver, cerebrovascular disease, and influenza and pneumonia. These seven causes of death which accounted for 64 percent of the total Indian and Alaska Native deaths in 1976, have changed little in order of importance over the years. Accidents continue as the leading cause with a crude death rate of almost three times that of the general population — 139.6 deaths per 100,000 to 46.8 for U.S. All Races.

Facilities and Services Utilization

SERVICE POPULATION

The estimated number of Indians and Alaska Natives eligible for IHS services in 1978 was about 678,000. Most of them live on reservations in 25 States and in isolated villages in Alaska. Following are estimated numbers by Indian Health Service administrative areas:

Aberdeen Area (S. Dak., N. Dak., Nebr., Iowa)	55,000
Alaska Area	69,000
Albuquerque Area (Parts of N. Mex., and Colo.)	45,000
Bemidji Program (Mich., Minn., Wisc.)	30,000
Billings Area (Mont., Wyo.)	35,000
Oklahoma City Area (Okla., Kans.)	127,000
Phoenix Area (Nev. Utah, parts of Ariz., Ore. and Cal.)	72,000
Portland Area (Idaho, Ore., Wash.)	34,000
Navajo Area (Parts of Ariz., N. Mex., Utah)	133,000
Tucson Program (Parts of Ariz.)	14,000
United Southeastern Tribes Prog. (Fla., La., Miss., N.C., N.Y.)	21,000
California Program	43,000

UTILIZATION

PHS Indian Hospitals and Contract Hospitals

The Indian Health Service operates 51 general hospitals, most of which are located in Arizona, New Mexico, Oklahoma, South Dakota and Alaska. The range of services provided includes medicine and surgery, obstetrics, tuberculosis and neuropsychiatry. The total available beds in IHS hospitals in F.Y. 1977 numbered 2,286 (excluding bassinets for newborn). In addition to the PHS Indian hospitals, about 1,000 beds are available through contractual arrangements with several hundred community general hospitals and State and local government tuberculosis and mental hospitals.

Illnesses Requiring Hospital Services

Illnesses and diseases for which Indian and Alaska Natives are hospitalized provide one of the important indices for identifying health problems:

Leading causes of hospitalization in fiscal year 1977 were:

1. Complications of pregnancy, childbirth and puerperium
2. Accidents, poisonings and violence
3. Diseases of the respiratory system
4. Diseases of the digestive system
5. Mental disorders

Hospital Inpatient Services

Discharges for persons under 15 years old accounted for 22.3 percent of the total number of discharges in 1977. This compares with 33.2 percent in 1967. The percentage in the other age categories have all increased since 1967.

NUMBER OF DISCHARGES AND PERCENT DISTRIBUTION BY AGE GROUP IHS AND CONTRACT GENERAL HOSPITALS FY 1967 AND 1977*

Age Group	*1977*	*1967*
Number of Discharges	106,290	85.237
Percent Distribution	100.0	100.0
Under 15 years	22.3	33.2
15 - 44 years	53.2	46.1
45 - 64 years	15.0	13.3
65 years and older	9.5	7.2
Age Unknown	0.1	0.2

Admissions to all hospitals, including those under contract, increased almost 119 percent between fiscal years 1955 and 1977. Approximately 29 percent of the admissions in 1977 were to contract hospitals. The types of admissions were distributed as follows:

Types of Medical Service	*Percent of Total*
Medical and Surgical	
Adult	55.2
Pediatric	22.6
Obstetric	19.4
Tuberculosis	0.2
Neuropsychiatric	2.6
Total	100.0

*Provisional

Outpatient Visits
Fiscal Year 1977

Visits to PHS Indian hospital clinics . 1,715,114
Visits to Indian Health Centers, satellite field clinics, schools and other units 1,245,736
Visits to contract physicians 259,507

Dental Services
Fiscal Year 1977

	IHS Dental Clinicians	*Contract Dentists*
Patients Examined	172,325	59,767
Corrective and Preventive Services	823,328	214,312

The estimated population treated was 35 percent in 1977. Corrective and preventive services provided in 1977 (1,037,640) increased 90.2 percent over 1971 since the level just ten years ago.

INDIAN HEALTH SERVICE FACILITIES

Hospitals

Location	No. of Beds	Outpatient Visits, 1977
Alaska		
Anchorage	170	88,699
Barrow	13	17,661
Bethel	42	43,371
Kanakanak	29	13,688
Kotzebue	40	20,838
Mt. Edgecumbe	82	17,710
St. George	6	2,217
St. Paul	4	4,478
Tanana	20	6,677
Arizona		
Ft. Defiance	76	77,144
Keams Canyon	38	37,043
Parker	20	17,031
Phoenix	168	111,928
Sacaton	30	26,016
San Carlos	36	33,855
Sells	40	31,382
Tuba City	108	85,391
Whiteriver	38	45,873
Winslow*	40	20,283
California		
Winterhaven	19	16,372
Minnesota		
Cass Lake	22	23,487
Red Lake	30	30,613
Mississippi		
Philadelphia	40	23,082
Montana		
Browning	34	42,399
Crow Agency	34	31,088
Harlem	18	16,366
Nebraska		
Winnebago	39	22,444
Nevada		
Owyhee	15	11,225
Schurz	26	7,357
New Mexico		
Albuquerque	54	34,305
Crownpoint	46	26,497
Gallup	181	102,115
Mescalero	15	16,862
Santa Fe	35	20,413
Shiprock	69	45,589
Zuni	35	30,046
North Carolina		
Cherokee	26	39,828
North Dakota		
Belcourt	50	39,720
Ft. Yates	32	19,217
Oklahoma		
Claremore	50	50,523
Clinton	14	15,570
Lawton	52	54,721
Pawnee	14	21,544
Tahlequah	40	67,528
Talihina	52	30,671
South Dakota		
Eagle Butte	33	34,572
Pine Ridge	58	40,696
Rapid City	54	25,747
Rosebud	41	38,700
Sisseton	32	17,879
Wagner	26	16,653
Totals:		
No. of Hospitals		51
No. of Beds Available		2,286
No. of Outpatient Visits, 1977		1,715,114

*Winslow hospital closed 7/1/77. Two new hospitals will open in fiscal year 1978 in Acomita Laguna Cañoncito, New Mexico and in Ada, Oklahoma.

HEALTH CENTERS

Location	Visits in 1977
Alaska	
Fairbanks	19,294
Ft. Yukon	3,221
Juneau	18,581
Ketchikan	11,886
Metlakatla	3,931
Mt. Edgecumbe*	3,754
Nome**	-
Arizona	
Bylas	8,470
Chinle (2)	67,324
Cibecue	4,929
Dilkon	6,988
Gila Crossing	7,833
Holbrook*	1,402
Kayenta	31,967
Leupp*	3,689
Lower Greasewood*	5,083
Many Farms (2)	10,374
Peach Springs	7,135
Phoenix*	5,364
Salt River	7,868
Santa Rosa	5,447
Second Mesa	4,404
Shonto	7,510
Teec Nos Pos	7,217
Toyei	264
Tuba City*	5,689
Tucson	10,516
California	
Riverside*	8,652
Colorado	
Ignacio	7,867
Florida	
Big Cypress	3,431
Brighton	4,274
Miccosukee	4,897
Hollywood	3,754
Idaho	
Fort Hall	16,918
Lapawi	7,518
Kansas	
Holton	8,114
Lawrence*	8,737
Minnesota	
White Earth	15,249
Montana	
Lame Deer	19,639
Poplar	24,306
Rocky Boy's	14,881
St. Ignatius**	824
Wolf Point	12,060
Polson	-

Location	Visits in 1977
Nevada	
Stewart	4,339
New Mexico	
Albuquerque	2,480
Chuska Tahatchi*	-
Crownpoint*	1,524
Dulce	13,462
Ft. Wingate (2)	10,792
Laguna	19,138
Sanostee*	2,425
Shiprock*	1,380
Southwestern Polytechnical*	6,307
Taos	8,294
Tohatchi	12,462
North Dakota	
Ft. Totten	18,431
Minni-Tohe (Four Bears)	8,575
Oklahoma	
Anadarko	16,209
Chilocco*	2,049
Concho*	596
Eufaula	7,990
Hartshorne*	1,643
Hugo	8,927
John Anderson	11,487
Jay	10,780
Okemah	8,978
Okmulgee**	-
McAlester	8,684
Pawhuska	2,708
Shawnee	34,620
Sequoyah*	472
Tishomingo	15,747
Watonga	5,711
White Eagle	13,488
Wyandotte (Seneca)	4,044
Miami***	-
Wewoka***	-
Oregon	
Chemawa*	5,316
Warm Springs	19,634
South Dakota	
Flandreau*	6,639
McLaughlin	10,120
Pierre*	-
Wanblee	7,320
Wahpeton*	7,982

Location	Visits in 1977
Utah	
Ft. Duchesne	13,289
Brigham City*	12,737
Washington	
Colville	11,373
Lummi	13,239
Neah Bay	11,442
Wellpinit	10,081
Taholah	8,486
Yakima (Toppenish)	32,983
Umatilla	4,921
Wyoming	
Araphoe	16,229
Ft. Washakie	23,560
Totals:	
No. of Visits in 1977	910,356
No. of Health Centers	99

* - School health centers
** - Medical services provided by contract medical care facilities
*** - New facilities

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Rockville, Maryland 20857

Areas

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